# GROUP INSURANCE ENROLLMENT CARD

**BOSTON MUTUAL LIFE INSURANCE COMPANY • 120 ROYALL STREET • CANTON, MASSACHUSETTS 02021-9968 • 1-800-669-2668**

| GROUP NUMBER | DIVISION NUMBER | EMPLOYER (POLICYHOLDER) NAME |
|---|---|---|
| | | |

| SOCIAL SECURITY NUMBER | DATE OF HIRE | EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) |
|---|---|---|
| ___ - ___ - ____ | | |

| STATE | CLASS | SEX (M or F) | OCCUPATION OR JOB TITLE |
|---|---|---|---|
| | | | |

NAME OF BENEFICIARY:
Primary Beneficiary _____ Relationship _____

SALARY TYPE:
☐ Hourly (40-hour week) ☐ Weekly
☐ Monthly ☐ Annual ☐ _____ $ _____

EARNINGS

Contingent Beneficiary(ies) _____ Relationship _____

| DATE OF BIRTH | AVG. HOURS WORKED | EFFECTIVE DATE | DEPARTMENT ID. |
|---|---|---|---|
| | | | |

OF THE COVERAGES AVAILABLE, I ELECT (✓):

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Life | ☐ | ☐ | Weekly Disability Income | ☐ | ☐ | Dependent Life: ☐ Spouse ☐ Dependent Children ☐ Both |
| ☐ | ☐ | Accidental Death & Dismemberment | ☐ | ☐ | Long-Term Disability | ☐ | ☐ | Major Medical: ☐ Employee Only ☐Employee & Spouse ☐Employee & Children ☐Employee & Family |
| | | | ☐ | ☐ | Other: _____ | | | |

Spouse Name _____
Spouse Birthdate _____ No. of Dependents _____

I apply for the insurance for which I am now eligible (or for which I may become eligible) under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. I UNDERSTAND THAT IF I AM DISABLED ON THE DATE MY INSURANCE WOULD OTHERWISE BECOME EFFECITVE, I SHALL ONLY BECOME INSURED ON THE DATE I RETURN TO ACTIVE FULL-TIME WORK. I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

DATE _____ SIGNATURE OF EMPLOYEE _____

PLEASE INDICATE AMOUNT OF INSURANCE: Life $_____ AD&D $_____ WDI $_____ LTD $_____ Other $_____

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ORIGINAL: INSURANCE COMPANY
COPY: EMPLOYER